Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

HARRIS METHODIST - NORTHWEST
3255 WEST PIONEER PKWY
ARLINGTON TX 76013

Respondent Name

FACILITY INSURANCE CORPORATION

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-07-3342-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We have sent proof of timely file to the carrier multiple times and the carrier refuses to process the claim for payment. Our proof of timely file includes 2 send back letters from the audit company. These letters show the claim was received and acknowledged by their company in a timely manner."

Amount in Dispute: $351.86

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Carrier properly denied the payment of the attached complete bill as is [sic] was not submitted within 95 days of the date of service... Requestor claims it submitted this bill twice within the 95-day period. However, Requestor did not submit a complete bill within that period. The initial incomplete bills were properly returned. Each resubmission was a new bill at [sic] it contained material changes. Carrier had to return each bill as it was still incomplete. The initial submissions failed to contain properly complete d required sections. The first bill to be complete was a new bill and was not timely. Requestor is charged with the knowledge of the requirements for completion of a UB-92 and carriers should not have to return bill repeatedly."

Response Submitted by: Flahive, Ogden & Latson, 504 Lavaca, Suite 1000, Austin Texas 78701

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
June 30, 2006	Outpatient Hospital Services	$351.86	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 Texas Administrative Code §133.3 sets out requirements for communication between health care providers and insurance carriers.
3. 28 Texas Administrative Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.
4. 28 Texas Administrative Code §133.200 sets out the procedures for an insurance carrier to return an incomplete medical bill to the health care provider.
5. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
6. Texas Labor Code §408.027 sets out the rules for timely submission of a claim by a health care provider.
7. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
8. This request for medical fee dispute resolution was received by the Division on January 29, 2007.
9. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 29 – The time limit for filing has expired.
   - 29 – HCPs must submit a bill for payment not later than the 95th day after the date on which the health care services were provided. Failure to timely submit a bill constitutes a forfeiture of right to reimbursement.
   - W4 – No additional reimbursement allowed after review of appeal/reconsideration.

Findings

1. The insurance carrier denied disputed services with reason code 29, stating "The time limit for filing has expired" and "HCPs must submit a bill for payment not later than the 95th day after the date on which the health care services were provided. Failure to timely submit a bill constitutes a forfeiture of right to reimbursement." 28 Texas Administrative Code §133.20(b), effective May 2, 2006, 31 *Texas Register* 3544 states, in pertinent part, that "A health care provider shall not submit a medical bill later than the 95th day after the date the services are provided." Texas Labor Code §408.027(a) states, in pertinent part, that "Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment." The requestor's rationale for increased reimbursement from the *Table of Disputed Services* asserts that "Our proof of timely file includes 2 send back letters from the audit company. These letters show the claim was received and acknowledged by their company in a timely manner." However, the respondent contends that "Requestor claims it submitted this bill twice within the 95-day period. However, Requestor did not submit a complete bill within that period. The initial incomplete bills were properly returned. Each resubmission was a new bill at [sic] it contained material changes. Carrier had to return each bill as it was still incomplete. The initial submissions failed to contain properly complete d required sections. The first bill to be complete was a new bill and was not timely." 28 Texas Administrative Code §133.200(b), effective May 2, 2006, 31 *Texas Register* 3544, requires that "An insurance carrier shall not return a medical bill except as provided in subsection (a) of this section. When returning a medical bill, the insurance carrier shall include a document identifying the reason(s) for returning the bill." Review of the Return to Provider letter dated July 18, 2006 finds that the insurance carrier's audit company, Forté, returned the initial medical bill for the disputed services with the comments: "PLEASE COMPLETE THE BILL IN ACCORDANCE WITH THE FOLLOWING: DWC 68 INSTRUCTIONS FOR COMPLETING THE UB-92… DWC 70 INSTRUCTIONS FOR COMPLETING THE ADA J515 DENTAL CLAIM FORM… DWC 67 INSTRUCTIONS FOR COMPLETING THE CMS 1500… DWC 66 INSTRUCTIONS FOR COMPLETING STATEMENT OF PHARMACY SERVICES." No documentation of the reasons for the return of the bill was found. Furthermore, 28 Texas Administrative Code §133.3(a), effective May 2, 2006, 31 *Texas Register* 3544, requires that "Any communication between the health care provider and insurance carrier related to medical bill processing shall be of sufficient, specific detail to allow the responder to easily identify the information required to resolve the issue or question related to the medical bill. Generic statements that simply state a conclusion such as 'insurance carrier improperly reduced the bill' or 'health care provider did not document' or other similar phrases with no further description of the factual basis for the sender's position does not satisfy the requirements of this section." Further review of the respondent's Return to Provider letter dated July 18, 2006 finds that the comments were generic statements that were not of sufficient, specific detail to allow the health care provider to easily identify the information required to resolve the issue or question related to the medical bill. Therefore, the Division finds that the insurance carrier did not meet the requirements of §133.3 or §133.200. The submitted documentation supports that the medical bill was submitted not later than the 95th day after the date on which the health care services were provided. The Division concludes that the respondent's denial reason is not supported and that the requestor has not forfeited the right to reimbursement; therefore, the disputed services will be reviewed per applicable Division rules and fee guidelines.
2. This dispute relates to services with reimbursement subject to the provisions of Texas Administrative Code §134.1, effective May 2, 2006, 31 *Texas Register* 3561, which requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care

network shall be made in accordance with subsection §134.1(d) which states that "Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available."

3. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
4. 28 Texas Administrative Code §133.307(c)(2)(G), effective December 31, 2006, 31 *Texas Register* 10314, applicable to disputes filed on or after January 15, 2007, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable." Review of the submitted documentation finds that:
   - The requestor has not articulated a methodology under which fair and reasonable reimbursement should be calculated.
   - The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
   - The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
   - The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

   The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	February 24, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.